UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ALASKA

KIMBERLY ALLEN, PERSONAL REPRESENTATIVE OF THE ESTATE OF TODD ALLEN, INDIVIDUALLY, ON BEHALF OF THE ESTATE OF TODD ALLEN AND ON BEHALF OF THE MINOR CHILD, PRESLEY GRACE ALLEN, PETITIONER, vs. UNITED STATES OF AMERICA, RESPONDENT,	No. 03:04-CV-0131-JKS

This is the discovery deposition of DR. SUSAN SHOTT, Ph.D, taken in the above-entitled cause before GWENDOLYN BEDFORD, a Notary Public and Certified Shorthand Reporter within and for the County of Cook, State of Illinois, taken at the Amata Office Suites, 150 North Michigan Avenue, 28th Floor, Chicago, Illinois, held on the 2nd day of May, 2006 at the hour of 1:30 o'clock p.m. pursuant to notice.

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A Probably not much at all. Because over and over again, what we find in the literature is what is stated here, that the neurological condition of the patient on admission, particularly level of consciousness, is the most important determinate of how they are going to end up.

Q And let me see if I am clear on that. So even if we were able to come up with evidence that Mr. Allen had bled extensively prior to showing up at ANMC, that would not change your opinion in this regard?

A No, because his neurological condition was so good and that is the Number 1 prognostic factor.

Q And if I could state it conversely then, if Mr. Allen did have extensive bleeding before he showed up at ANMC that morning, you would not consider that to be a negative factor with regard to predicting his outcome?

A Not given his neurologic condition.

MS. MCREADY: My objection to the question, I guess you can sort of let it stand, but there is sort of inconsistent -- I mean, you know -- never mind. I just don't think the question makes sense, but you can ask it and she can answer if she can.

BY MR. GUARINO:

Q I guess I am just trying to find out. We don't have any information, but you're telling me that it really wouldn't matter what the answer was, because even if he had extensive bleeding before he showed up at ANMC, you think since his

neurological status was intact when he showed up, that is the prime predictor of his outcome?

A That is what the research shows.

Q What about the question of rebleeding. Do you know what I am referring to?

A Yes.

Q And in fact if you look at the next page of your report, you cite one article referenced 26 that notes that one of the main problems for patients with subarachnoid hemorrhage, is that they may have an episode of rebleeding. Do you see that?

A Yes.

Q Would it be fair to say that patients who experience an episode of rebleeding before they receive treatment have worse outcomes?

A That's a good question.

MS. MCREADY: I need to lodge an objection, because I think the word "treatment" is ambiguous. Do you mean surgery or medical treatment?

MR. GUARINO: I can break it up, but let's start with just the basic concept.

BY MR. GUARINO:

Q Do patients who experience rebleeding, patients with subarachnoid hemorrhage, who have had an initial bleed and then have a rebleed, do they have worse outcomes?

A That is obviously not a good thing to have a rebleed,

but what you have to bear in mind is the fact that the studies that look at the neurological condition of the patient on admission and find that that's, if it is -- if they are in good condition, that is a very positive factor for outcome, those studies will include patients who came in in good condition and subsequently had a rebleed before they were treated. Those patients are inevitably going to be included those studies.

Q And when you say they are inevitably included, can you point to the parts of the study that you have cited where they identify patients, specifically patients who came in and neurologically intact and had a rebleed and still had good outcome?

A Unless they state that the patients were specifically excluded, unless those are exclusion criteria, those patients are almost inevitably going to be in those studies. And there is well-known cases in the literature where patients have come in in good condition, they have had a rebleed and they have nonetheless had good outcomes.

Q The question is for purposes of comparison, would you expect based on your knowledge of the research that patients who experience rebleeding are more likely to have bad outcomes than patients who don't experience rebleeding?

A That would certainly be true.

Q And, in fact, if you look at one of the references, Reference 23, let's see if I can -- it is the article titled

"Stroke".

A What is the number for the reference?

Q Number 23 according to your list in your report.

A Okay.

Q Do you have that article?

A Let me check. Yes, I do.

Q If you look at the opening paragraph of that article, "Subarachnoid hemorrhage accounts for 25 percent of all cerebral vascular deaths. The fatality rate of subarachnoid hemorrhage is reported to be as high as 50 percent. Among the remaining survivors, 50 percent are less severely disabled. The ideology of 80 percent of the cases is ruptured intracranial aneurysm. Morbidity and mortality are largely due to rebleeding aneurysms and vaso spasm." Do you see that?

A Yes.

Q At least according to the report, the morbidity and mortality are based on whether patients experience rebleeding or vaso spasm?

A That's correct.

Q So in your assessment, did you assess whether Mr. Allen experienced any episode of rebleeding on the morning or afternoon when he presented at ANMC?

A Indirectly in the sense that the studies that look at the neurological condition at admission, again do include patients that experience a rebleed. Unless they specifically

Q And I am going to use a little bit of an extreme example here just to test the definition. If someone walks in the emergency room and they are a Grade 1 and 45 minutes later, while they are in the emergency room, their aneurysm bursts and they go into a coma, you would still consider them Grade 1 on admission?

A That is the way it is done. That's correct.

Q And that would be true for any time period after they walk in the door and have the first contact with the provider. If they're a Grade 1 or 2 when they walk in the door and see the provider, whether it is a doctor or nurse care provider, if a half hour later or an hour later or two hours later, they have a catastrophic event, they go into coma, you would still classify them as Grade 1 or Grade 2?

A On admission. Yes, that is the definition of the terms and that is how it is used in the literature.

Q And that is the way you're using it in your report?

A I'm using it in the way that is consistent with the literature. That's correct.

Q And your report lumps together all patients that show up at the door and are seen by a provider at whatever grade they're at. And it lumps them with any other patient who may have shown up at a Grade 1 or Grade 2, but within an hour or two hours or three hours has a severe change in status. Your report would lump all those together and consider them all to be what

they were when they first walked in the door?

A As does the literature, yes. My report is consistent with the way that term is used in the literature and that is how it's used.

Q And I did it to you and I apologize. I went off on a tangent and now I am coming back to an earlier question. In terms of the location of the aneurysm, could the location of the aneurysm affect the surgical procedure that would be used?

A I would assume so, but at this point I don't recall the manner in which that would be affected.

Q And, Doctor, I want to be real careful. Your assumptions don't really help me or give me any information unless they're based on either your professional experience or your research. I would like to be careful. What I would like to know is whether you have any basis to offer an opinion about whether the location of the aneurysm may affect what surgical procedure would be used?

A Not that I recall at this time. But that doesn't mean that I haven't reviewed something at some point that is relevant to the question. I do not recall anything as I sit here today.

Q And in terms of -- well, let me ask you, do you have any way to know whether the location might make the surgery more difficult?

A Again, not that I recall at this time.

Q And assume for the moment that some patients have

aneurysms that are more difficult to operate on than others, is that a factor that you would consider in terms of predicting their outcomes?

A Again, I am repeating myself, but it would depend on how you did the analysis. And again, I'm repeating myself, but it bears repeating. When you do a multivaried analysis there is all kinds of factors, that might be related. And your goal is to find the things that really stand out, so that once you take that into account, these other factors sort of fall into a relevance once you have taken into account these major factors.

Yes, those things might matter if you look at them just by themselves, but they turn out not to matter if you have already taken into account the primary prognosticator which is the condition on admission.

Q Is it your opinion that the condition on admission gives you enough information about the difficulty of the surgery that might be required to treat that person that you don't need separately consider the difficulty of the surgery?

MS. MCREADY: Objection.

THE WITNESS: No. Are we taking about outcome or the nature of the surgery? What are we trying to predict here, the nature of the surgery or the outcome?

BY MR. GUARINO:

Q It is a longer connection than that. I asked you whether the location of the aneurysm might cause the the

difference in the surgical procedure and your answer is your answer. I don't want to go back through it. And then I asked you whether the location of the aneurysm might result in the surgery being more difficult to perform. And again your answer is your answer and I don't need to go back through it. But my follow-up question is assuming that the aneurysm was -- that the surgery was more difficult to perform, either because of the size or the location or some other factor, is that something that you would consider before you would determine what the person's likelihood of having a good outcome was?

A Not unless I saw good quality research that indicated that once you have taken into account condition on admission, that remains an important factor.

Q We've got some background beeping.

A That was my pager, but we can ignore that.

Q And so I want to be clear. Your view is as long as you know what the condition is of the patient when they walk in the door, you don't need to look at whether their surgery is going to be more difficult than another patient in order to predict their outcome?

A My view is the research has consistently shown that once you have taken into account the patient's initial condition, other factors which by themselves would matter, and which common sense tells you matters, simply do not have a significant impact on determining or predicting the outcome.